Newcomers Orientation 2004

Devin Park
18th MEDCOM RM Coordinator
736-6097

Risk management

- Provides for the early identification and investigation of incidents occurring in the MTF.
- By identifying, investigating,and implementing changes, our Health Care System reduces or eliminates future risks to patients, visitors, or staff.
- We then provide a better heath care delivery system to our patients, and minimize the financial loss to the government.

Mistakes Happen

- **Despite your best efforts** to do otherwise, every once in a while you may make a mistake when providing care to a patient.
- Incident reports allow us to look at the organizations system and see where there is a weakness.
- **System improvements** eliminate errors.

Reporting Errors

- DA Form 4106 must be completed for all incidents involving any action **not within the intended plan of care.**
- DA form 4106 should be filled out by the person involved, or by the person who discovered the incident.
- DA form 4106 is then **submitted to your supervisor, with in 24 hrs**. It is then submitted to the Risk Management Office.

Incident Report

- ***Information must be factual, concise and with out personal opinions.***
- DA form 4106 can be printed from the computer. Click the **AMEDD E-Forms icon**. Then click Dept. of Army, and its under forms DA 4065 R. Print after completion.
- DA form 4106 initiates an Interdisciplinary Review process.
- Provides prompt feedback
- **Not meant to be punitive, and is protected from release.**

Documentation

- **Incident reports are not documented in the pt. medical record**. Only the facts of the event, and what you did for the pt. (ie, contacted the PCP, implemented any orders, the pt. status).
- Document each intervention initiated.
- Complete and accurate records are **the best defense in litigation.**
- If it is not documented, it did not happen.

Share the Knowledge

- **Everyone** makes mistakes

  (any healthcare provider who claims to have never made a mistake is in denial)

  - If you're distracted**,** errors can easily occur.
  - Use checklists, follow SOP, 5 rights
  - If you have **ANY** doubt, ask questions
- Share those mistakes
  - Complete near miss or DA 4106 forms
  - Talk to, and support your fellow workers
- Those mistakes,can educate others, and create system changes

Change the System

- Health care providers have been socialized to expect punishment following an error.
- Anyone can make a mistake, this does not measure the quality of care given to a patient.
- Incident reporting can provide an **opportunity** for learning, and an **opportunity** to improve supervisor/staff interaction
- Incident reporting is used for **improvement not punishment.**

Sentinel Event

- A sentinel event is an unexpected occurrence involving **death or serious physical or psychological injury**, or risk thereof.
- Such events are called “sentinel” because they signal the need for **immediate investigation** and response by the organization.

Sentinel Event

- Since this is the Big Kahuna of all incidents, your supervisor, and the Commander must be notified immediately.

Nothing leaves the area where the event occurred. All equipment and medications remain in the area. Nothing is turned off. This is vital to the investigation.

Support those involved, this is a devastating event for all involved.